STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

January 30, 2019

Mr. Vincent Capece, Jr, CEO
Middlesex Hospital
28 Crescent St
Middletown, CT 06457

Dear Mr. Capece:

Unannounced visits were made to Middlesex Hospital that concluded on January 4, 2019 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigation with additional information received through January 4, 2019.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which/were noted during the course of the visits.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by February 13, 2019

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the

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DATES OF VISIT: January 3 and 4, 2019

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

violations are not responded to by **February 13, 2019** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC/LH:jf

Complaints #24470, #24483

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6).

1. Based on medical record reviews, review of facility documentation and video, review of facility policies, observations and interviews, for one of three patients who required constant observations (Patient #1), the facility failed to ensure that the patient was constantly observed. The finding includes:

    a. Patient #1 had a history of Bipolar disorder, was brought to the ED (emergency department) on 11/5/18 and had a cystoscopy for retrieval of a nail that had been self-inserted into Patient #1's urethra. Patient #1 was admitted to the ED "Red Zone" on 11/12/18 with self- injurious behavior and had undergone a cystoscopy for removal of a self- inserted nail into the urethra. A tour of the ED on 1/3/19 at 11:04 AM noted that the "Red Zone" consisted of two single, side by side patient rooms. Review of a video recording on 1/3/19 at 9:46 AM dated 11/12/18 identified S.O. (Security Officer) #1 observing the patient in the Red Zone. Patient #1 ambulated to the BR (bathroom) in the hall, closed the BR door and S.O. #1 remained in the hallway approximately 10 feet away and without the patient in constant view. An addendum ED MD note dated 1/13/18 indicated that Patient #1 had inserted plastic utensils into his/her urethra when escorted to the BR by SO #1. The cystoscopy report dated 11/13/18 identified the retrieval of two plastic foreign body handles.

    Review of Patient #1's record and interview with Director #1 on 1/3/19 at 9:45 AM indicated that although the ED MD ordered every fifteen minute observation for Patient #1, patients in the Red Zone are on CO (constant observation). She further noted that SO #1 should have followed the patient to the BR to maintain observation of the patient however, did not do so. Review of personnel files on 1/4/18 identified that, following the incident, S.O. #1 was terminated on 11/20/18 for failure to monitor Patient #1 per facility policy.

    The facility policy for observation of patients identified that patients are within the direct field of vision of staff at all times when on one- to- one and constant observation.

    b. Patient #1 was a direct admitted from the 11/7/18 ED admission to the N7 BHU (behavioral health unit) on 11/14/18. Review of the psychiatric MD progress note dated 11/14/18 identified a plan to maintain one- to- one observation. Review of nursing narratives dated 11/15/18 at 12:50 PM indicated that Patient #1 remained on one-to-one with security. A video recording dated 11/15/18 was reviewed on 1/3/18 10:12 AM. The recording identified that on 11/15/18 at 12:54 PM, Patient #1 was being

observed by SO #2, SO #2 looked out of the window for a couple of seconds and did not observe Patient #1 reach into the garbage bag near the nursing station. Patient #1 then went into his/her bed, pulled the covers over his/her body and hands were beneath the covers. Review of social service notes dated 11/15/18 at 1:44 identified that Patient #1 admitted that he/she stole a fork and inserted it into his/her urethra. Nursing narratives dated 11/15/18 at 1:56 PM identified that the patient was evaluated by the MD. Patient #1 was placed on two-to-one observation following the incident. Review of the cystoscopy report dated 11/15/18 noted that two plastic foreign bodies were retrieved from the patient's urethra.

Interview with Director #1 on 1/3/19 at 10:20 AM identified that SO #2 should have had eyes on the patient at all times. Interview with SO #2 on 1/3/19 at

12:09 PM indicated that he was looking out of the window when Patient #1 reached into the garbage and that he had not had any formal training on the facility one-to-one observation policy prior to the event.

The facility policy for observation of patients identified that patients are within the direct field of vision of staff at all times when on one- to- one and constant observation.

Subsequent to the events, the facility submitted CAPs (corrective action plan) dated 11/16/18 and 12/6/18 to include education for security and nursing staff of the current policy for observation of patients, the development of a utensil monitoring procedure for the BHU with the development of a stricter patient observation policy for facility governing board approval. The facility was found to be compliant with the CAP as submitted.

2. Based on medical record reviews, review of facility documentation and video recordings, review of facility policies, observations and interviews for two of three patients (Patient #2) who resided on the N7 BHU (behavioral health unit), the facility failed to ensure that the unit was monitored adequately to prevent an alleged sexual assault.

   The finding includes:

   c. Patient #1 had a history of Bipolar disorder and was admitted to the BHU on 11/7/18 on every fifteen minute checks. Patient #2 was 29y/o, had a history of Schizo-affective

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disorder, sexual trauma, was developmentally delayed with mild to moderate intellectual disability and was admitted to the BHU on 11/8/18 for suicidal ideation. Patient #2 was placed on every fifteen minute checks on 11/8/18 at 2:45 PM per the physician order. Review of the monitoring sheets for Patient #1 dated 11/8/18 at 4:45 PM indicated that he/she was talking to staff/others and was eating at 5:00 PM. Patient #1 was discharged to home on 11/9/18. Review of monitoring sheets dated 11/8/18 identified that Patient #2 was talking to staff/others at 4:45 PM and was eating at 5:00 PM. Review of MD notes for Patient #2 dated 11/10/18 indicated that Patient #2 alleged that Patient #1 came into his/her room the night that he/she was admitted (11/8/18) and that he/she was sexually assaulted by Patient #1. Patient #2 was subsequently tested for sexually transmitted diseases, a rape test kit was performed and results were negative. The video recording dated 11/8/18 from 4:38 PM to 4:44 PM identified Patient #1 and Patient #2 in the common area at the table drawing pictures and touching each other's peri area and/or touching the other's breast. Further review identified that Patient #2 went into his/her bedroom and Patient #1 entered Patient #2's bedroom and closed the door. Patient #1 was observed on the video to leave Patient #2's room at 4:55 PM and both patients were observed sitting next to each other in the common room eating dinner and interacting at 5:01 PM.

Interview with Manager #1 on 1/3/19 at 11:35 AM indicated that PCT #2 (patient care tech) was in charge of the 15 minute checks of the BHU patients on 11/8/18 and assisted with a patient admission between checks and during the time of the incident. Further interview identified that the person assigned to 15 minute checks was responsible for the safety of the unit.

Although the facility policy for patient observation did not include monitoring of the common area, the facility patient rights policy indicated that the patient had the right to safe care at all times.

Subsequent to the event, the facility submitted a CAP (corrective action plan) to include incorporation of the staff assigned to the common area onto the nursing assignment sheets, education of staff on "full unit" observation and changes to the patient observation policy. The facility was found to be compliant with the CAP as submitted.

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